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No. 03-

IN THE

Supreme Court of the United States

MARGENE REID,

Petitioner,

v.

CAPITAL ONE FINANCIAL CORPORATION,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Employee Retirement Income Security Act of 1974 ("ERISA" and "Act") promotes the interests of employees and their beneficiaries in employee benefit plans, and protect contractually defined benefits. Since its enactment, courts have interpreted the Act to provide benefits at least as much as a personal insurance policy, and have strived to achieve a uniform interpretation of the Act and the benefits it provides to plan participates and beneficiaries. This Court recently held in *Black & Decker Disability Plan v. Nord*, 537 U.S. 1098, 123 S. Ct. 1965, 154 L. Ed. 2d 766 (2003), that although a plan administrator is not to give preference to the treating physicians, because the treating physicians rule used in Social Security claims does not apply to ERISA claims, the plan administrators may not arbitrarily refuse to credit the claimant's reliable evidence, including the opinions of treating physicians. Even though the Appellant relied on *Black & Decker* at the oral argument in this case, the Eleventh Circuit nonetheless held that the plan administrator need not look at, or even consider the treating physicians opinions or records, and instead may rely exclusively and dispositively on the report of the compulsory medical examiner to deny short term disability benefits, and as a result, deny eligibility for long term disability benefits.

The first question presented is whether *Black & Decker* also requires the plan administrator not to give preference to its chosen examiner, but is required to weigh all of the evidence of the medical condition of the participant before making a decision to deny or terminate benefits.

The second question presented is whether an ERISA qualified plan may contain and enforce a plan provision that requires the plan administrator's chosen examining physician's opinion to be dispositive of a disability claim, ignoring all treating physicians' opinions and medical records.

TABLE OF CONTENTS

	Page
Questions Presented	i
Table of Contents	iii
Table of Cited Authorities	v
Table of Appendices	x
Opinions Below	1
Statement of Jurisdiction	1
Statutory Provisions Involved	1
Statement of the Case	1
Reasons for Granting the Petition	7
I. Certiorari Is Warranted Because The Decision Below Conflicts With Decisions Of This Court And Of Other Circuits	8
A. Treating physicians' records must be weighed by the plan administrator	8
B. De novo standard of review was required to be used by the district court	10

Contents

Page

II. Certiorari Is Warranted Because The Decision Below Conflicts With, And Violates The Minimum Statutory Requirements Of ERISA 14

III. Certiorari Is Warranted Because The Decision Utilized The Wrong Standard Of Review .. 19

Conclusion 23

TABLE OF CITED AUTHORITIES

Page

Cases:

Baxter v. Lynn,
886 F.2d 182 (8th Cir. 1989) 13

Berry v. Ciba-Geigy Corp.,
761 F.2d 1003 (4th Cir.1985) 18

Black & Decker Disability Plan v. Nord,
537 U.S. 1098, 123 S. Ct. 1965, 154 L. Ed. 2d
766 (2003) ..... *passim*

Brown v. Retirement Committee of Briggs & Stratton Retirement Plan,
797 F.2d 521 (7th Cir. 1986), *cert. denied*, 479 U.S.
1094 (1987) 17, 20

Calvert v. Firstar Finance, Inc.,
266 F. Supp. 2d 578 (W.D. Kent. 2003) 9

Casey v. Uddeholm Corporation,
32 F.3d 1094 (7th Cir. 1994) 12

Chambers v. Family Health Plan Corp.,
100 F.3d 818 (10th Cir.1996) 21

Dobrowolsky v. Califano,
606 F.2d 403 (3rd Cir. 1979) 20

Donaho v. FMC Corporation,
74 F.3d 894 (8th Cir. 1995) 19

Cited Authorities

Page

Elliott v. Sara Lee Corporation,
190 F.3d 601(4th Cir. 1999) 22

Ellis v. Metropolitan Life Insurance Co.,
126 F.3d 228 (4th Cir. 1997) 22

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80
(1989) ..... *passim*

Gilbertson v. Allied Signal, Inc.,
328 F.3d 625 (10th Cir. 2003) 11

Grossmuller v. International Union Local 813,
715 F.2d 853 (3d Cir. 1983) 15

*Gunderson v. W. R. Grace & Co. Long Term
Disability Income Plan*,
874 F.2d 496 (8th Cir. 1988) 22

*Hackett v. Xerox Corp. Long-Term
Disability Income Plan*,
315 F.3d 771 (7th Cir. 2003) 9, 10, 18

Halpin v. W.W. Grainger, Incorporated,
962 F.2d 685 (7th Cir. 1992) 16, 17, 18

Kirwan v. Marriott Corporation,
10 F.3d 784 (11th Cir. 1994) 12, 13

Cited Authorities

Page

Lestrange v. Fortis Benefits Insurance Company,
2003 WL 21372162 (N.D. Iowa 2003) 9

Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,
46 F.3d 938 (9th Cir. 1995) 13

Moon v. American Home Assurance Co.,
888 F.2d 86 (11th Cir. 1989) 13

Pilot Life Insurance Co. v. Dedeaux,
481 U.S. 41 (1987) 14-15, 17

Quesinberry v. Life Insurance Company of North America,
987 F.2d 1017 (4th Cir. 1993) 14

Riley v. UNUM Insurance Company of America,
1998 WL 839881 (D. Kan. 1998) 20

Saffle v. Sierra Pacific Power Company Bargaining Unit Long Term Disability Income Plan,
85 F.3d 455 (9th Cir. 1996) 22

Sage v. Automation, Inc. Pension Plan & Trust,
845 F.2d 885 (10th Cir. 1988) 15

Sharkey v. Ultramar Energy Limited,
70 F.3d 226 (2d Cir. 1995) 12

Cited Authorities

Page

Sweatman v. Commercial Union Insurance Co.,
39 F.3d 594 (5th Cir. 1994) 14

Syed v. Hercules, Inc.,
214 F.3d 155 (3rd Cir.2000) 18

Taft v. Equitable Life Assurance Society,
9 F.3d 1469 (9th Cir.1993) 21

Turner v. Delta Family-Care Disability and Survivorship Plan,
291 F.3d 1270 (11th Cir. 2002) 9

Weaver v. Phoenix Home Life Mutual Ins. Co.,
990 F.2d 154 (4th Cir.1993) 18

Whatley v. CNA Insurance Companies,
189 F.3d 1310 (11th Cir. 1999) 12

Wolf v. J.C. Penney Co.,
710 F.2d 388 (7th Cir. 1983) 16

Young v. Secretary of Health & Human Services,
957 F.2d 386 (7th Cir. 1992) 17

Cited Authorities

Page

Statutes

28 U.S.C. § 1254(1) 1

Employee Retirement Income Security Act of 1974

29 U.S.C. §§ 1001-1461 1

29 U.S.C. § 1132(a)(1)(B) 10

29 U.S.C. § 1133(2) 14

Regulations

29 C.F.R. § 2560.503-1 15

29 C.F.R. § 2560.503-1(f)(3) 16

29 C.F.R. § 2560.503-1(h)(2)(ii) 15

29 C.F.R. § 2560.503-1(h)(2)(iv) 15

29 C.F.R. § 2560.503-1(h)(4) 15

TABLE OF APPENDICES

Page

Appendix A — Opinion Of The United States Court Of Appeals For The Eleventh Circuit Dated And Filed June 17, 2003 ..... 1a

Appendix B — Order Of The United States District Court For The Middle District Of Florida, Tampa Division Dated June 13, 2002 And Filed June 17, 2002 ..... 4a

Appendix C — Statutes And Regulations Involved ... 18a

Petitioner respectfully petitions for a writ of certiorari to review the decision of the United States Court of Appeal for the Eleventh Circuit.

OPINIONS BELOW

The district court's opinion (per Whittemore, D.J.) granting respondent's summary judgment motion (Appendix B) is a non-published opinion. The court of appeals opinion affirming the district court (Appendix A) is a non-published opinion.

STATEMENT OF JURISDICTION

The court of appeals entered its opinion on June 17, 2003. Petitioner invokes this Court's jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001-1461, and regulations relevant to this petition are reprinted in the Appendix C.

STATEMENT OF THE CASE

As will be shown below, the lower decision directly and substantially conflicts with *Black & Decker Disability Plan v. Nord*, 537 U.S. 1098, 123 S. Ct. 1965, 154 L. Ed. 2d 766 (2003). This is an appeal of an affirmance of a summary judgment entered in favor of the plan administrator denying a claim for disability benefits under an ERISA-regulated plan where the administrator relied exclusively on a compulsory medical examination, and ignored the records of the treating

physicians whose opinions on disability met the standard set forth in the Plan. Neither the administrator or the examiner reviewed the treating medical records before terminating benefits.

The Petitioner, Margene Reid, was a full time employee of Capital One Financial Services, Inc., (hereinafter referred to as Employer), located in Tampa, Florida. Employer provided its employees with a welfare benefits program (hereinafter referred to as the Plan). The Plan's written documentation provides that the Sponsor and Administrator is the Respondent, Capital One Financial Corporation (Capital One). The Plan provides that the Plan Sponsor, Capital One, is the Claims Administrator for purposes of reviewing denials of benefits. The Plan lists Aetna Insurance Company (Aetna), as the Insurance Company/Claims Administrator. The initial denial of short-term benefits, as well as the first appeal of the denial is delegated to Aetna. Aetna agreed to act as a fiduciary pursuant to ERISA.

The Plan provides that short-term disability lasts for 26 weeks, followed by long-term disability benefits. The short-term benefits are payable simply if the claimant is "unable to work" due to sickness or injury. The long-term benefits require the claimant to be totally disabled as defined in that section of the Plan. The pertinent part of the Short-Term disability section provides on page 97 of the Plan:

> Capital One values you as an important part of our organization and recognizes your contribution. That's why we want to help you recover from an illness or injury, and have you back on the job as soon as medically appropriate. The Short-Term Managed Income Protection plan pays benefits

> when you can't come to work because you are sick or injured. ***
>
> You, your doctor, Aetna's expert medical reviewers and Capital One MIP coordinator work together to determine the amount of time you need to be away from work to recover from your illness or injury. ***
>
> If your sick and can't come to work, your paycheck is protected by the Short-Term Managed Income Protection program, . . .

Thus, the short-term plan definition for eligibility for benefits is simply the employee cannot come to work due to injury or sickness. It does not require total disability.

After two rear-end automobile accidents in January and February, 1999, Margene Reid became disabled and did not work from February 21, 1999 through May 10, 1999. Margene Reid was granted short term disability benefits. From May 10,1999 to February 2, 2000, Margene Reid worked from 4 to 6 hours per day, but never returned to full time duty. After February 2, 2000, Margene Reid could not return to work due to her injuries sustained in these accidents as ordered by her treating physician, Paul D. Maas, D.O.

After the accidents, Margene Reid treated with her primary care physician under the Plan, Mary McGinn, M.D. Then, in May 1999, Margene Reid began treating with Paul D. Maas, D.O. as her primary treating physician for her injuries. Dr. Maas referred her to Shrinath S. Kamat, M.D. a neurologist. Margene Reid has also treated with James Homan, D.O. for fibromyalgia that resulted from the

accidents. Throughout her course of treatment, Dr. Maas had referred Margene Reid to a massage therapist and an acupuncturist in an attempt to relieve her pain. Although not provided for under the short-term section of the Plan, and only provided under the long-term disability section of the Plan, Capital One required Margene Reid to submit to a compulsory medical examination with Dr. Erick Grana, a physical medicine and rehabilitation doctor.

Capital One did not provide its examining physician, Dr. Grana, with any medical records of the treating medical providers: Thomas Boland, M.D., D.M.D. (oral and maxillofacial surgeon treating for temporomandibular disorder caused by the accidents); Shrinath Kamat, M.D. (neurologist); Mary McGinn, M.D. (family practice); Jeffrey Tedder, M.D. (orthopedic surgeon); James R. Homan, D.O. (general practice treating for fibromyalgia); Paul D. Maas, D.O. (pain management) or Total Women's Rehab (physical therapy). Dr. Grana was only furnished with Magnetic Resonance Imaging reports and the initial evaluation of Dr. Maas. Dr. Grana did not have any telephone conversations with Capital One or Aetna. Dr. Grana's examination excluded the temporomandibular joint, and Dr. Grana deferred to Thomas Boland, M.D., D.M.D. for any limitations and opinions regarding the temporomandibular joint because Dr. Grana conceded that Dr. Boland was in a better position to evaluate Margene Reid's condition. Dr. Thomas Boland found Margene Reid to be disabled.

Dr. Grana found that Margene Reid was not totally disabled, but he did find that her disability from her injuries should resolve in six months.

Petitioner was required to see Dr. Grana for a second examination, and again Dr. Grana did not have any medical records of treating physicians. Dr. Grana reported positive findings in the neck area including muscle spasms and tenderness to palpation, a decreased range of motion in both the neck and low back areas. In the first examination, he found a decreased sensation in the right hand and right leg. In the second examination, he found a decreased sensation in the entire right arm and again in the right leg. Dr. Grana found decreased muscle strength in the shoulders due to pain and less strength in the right hand. He also found that there was tenderness to palpation in the temporomandibular joint. Dr. Grana recommended that Margene Reid continue with the treatment she was receiving from Dr. Boland for the temporomandibular joint (TMJ) injury.

Dr. Grana classified as an abnormal finding the "extreme response" to a light touch in the neck and trapezius areas which precluded him from performing a deep palpation to test for muscle spasm or trigger points. Unknown to Dr. Grana, this was consistent with the findings of a treating physician, Mary McGinn, M.D. Dr. Grana diagnosed Margene Reid with tendinitis of both shoulders.

Dr. Grana recommended to Capital One that a functional capacity evaluation be performed to determine Margene Reid's ability to work. Capital One did not authorize the evaluation.

In his deposition, Dr. Grana testified that the temporomandibular joint disorder causes headaches, neck pain, clicking and popping of the jaw, and tinnitus in the ears. He also stated that if Margene Reid worked eight hours per day on a computer keyboard, she would experience an

exacerbation of the trapezius muscle pain. Dr. Grana also stated that Margene Reid continues to experience a disability from the shoulder tendinitis, the temporomandibular joint disorder and the cervical disk bulge. Capital One conceded that Margene Reid's employment with the Employer required strong oral communication skills, the ability to work for long periods of time on the telephone, and using a computer.

Neither Capital One or Aetna ever requested medical records from treating physicians. The Plan requires the nurses at Aetna to speak with the treating physicians to ascertain the claimant's diagnosis and treatment. The medical director of Aetna is required to telephone the treating physician to ascertain the specifics of an employee's case. These specific Plan requirements never occurred. Treating physicians verified by affidavits that they were never contacted by Capital One or Aetna.

Margene Reid received medical treatment several times per week throughout 1999. Capital One terminated short-term disability benefits solely due to the 1999 report of Dr. Grana on its contention that the compulsory examination controls as to whether benefits will be paid. Capital One contends that the Plan provides no discretion, and the compulsory examination report is dispositive. Capital One conceded that although it relied on the Dr. Grana's report, the report's findings were not clear. Capital One also conceded that the treating physicians found that Margene Reid met the standard of being totally disabled under the Plan to qualify for disability benefits.

James R. Homan, D.O., and Paul D. Maas, D.O., Thomas Boland, M.D., D.M.D., and Shrinath Kamat, M.D., all provided affidavits stating their opinions that Margene Reid is totally disabled.

Both the district court and the circuit court found that the Plan provides Capital One with discretion to interpret the Plan, precluding a *de novo* review, even though Capital One was steadfast in its position that the Plan does not provide any discretionary authority with respect to disability claims, because the compulsory examiner's report is dispositive.

The district court stated that the denial of benefits was not wrong because the Plan requires denial if the compulsory examiner's report does not certify disability. The circuit court agreed. The decision below conflicts with decisions of this Court and of other circuits, and even those of the Eleventh Circuit.

After the circuit court rendered its decision, this timely petition for a writ of certiorari followed.

REASONS FOR GRANTING THE PETITION

The petition should be granted for two reasons. *First*, ERISA, this Court's decision in *Black & Decker Disability Plan v. Nord*, 537 U.S. 1098, 123 S. Ct. 1965, 154 L. Ed. 2d 766 (2003), and decisions of circuit courts, require a plan administrator to consider all evidence presented by both parties, and that all evidence, including the medical records of the treating physicians, be considered when rendering a disability determination. Thousands of participants of the Capital One Plan, and millions of Americans nationwide who are participants in ERISA-regulated plans, will be affected if plan administrators are permitted to totally ignore treating physicians' opinions and medical records.

Second, The Petitioner's claim was required to be reviewed by the court under a *de novo* standard of review because Capital One had no discretion concerning the eligibility for disability benefits. The Plan, in effect, delegates the eligibility determination to the physician performing the compulsory examination, of which the Plan Administrator must follow. Thus, the decision below conflicts with *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 956, 103 L. Ed. 2d 80 (1989), and decisions of circuit courts.

I. Certiorari Is Warranted Because The Decision Below Conflicts With Decisions Of This Court And Of Other Circuits

A. Treating physicians' records must be weighed by the plan administrator

This Court in *Black & Decker Disability Plan v. Nord*, 537 U.S. 1098, 123 S. Ct. 1965, 154 L. Ed. 2d 766 (2003), in unanimously holding that the treating physicians rule does not apply to ERISA cases, stated that "Plan administrators, of course, may not arbitrarily refuse to credit the claimant's reliable evidence, including the opinions of a treating physician." *Id.*, at 1972. In weighing the medical evidence, this Court stated that the plan administrator can also consider the expertise or specialization of the treating and examining physicians. *Id.*, at 1971. This Court also recognized that "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Id.*, at 1970 (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, L. Ed. 2d 80 (1989).

Black & Decker, has been interpreted to mean that the plan administrator cannot arbitrarily refuse to credit the claimant's reliable evidence, including the opinions of the claimant's treating physicians. *Lestrange v. Fortis Benefits Insurance Company*, 2003 WL 21372162, *15 (N.D. Iowa 2003). *Black & Decker* also requires the court to determine whether the examining physician constitutes reliable evidence. *Id. Black & Decker* requires the court to examine the complete record. *Calvert v. Firstar Finance, Inc.*, 266 F. Supp. 2d 578, 585 (W.D. Kent. 2003). *Black & Decker* requires the plan administrator to view the claimant's reliable evidence as a whole, including the treating physicians' opinions. *Id.*, at 579.

Although the Eleventh Circuit did not follow the treating physicians rule in ERISA cases, *Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002), the court did require all medical reports and other evidence be considered. *Id.* Here, however, the lower court, contrary to its decision in *Turner*, permitted Capital One to violate the provisions and regulations of ERISA and make a determination based solely on its examiner's report.

In *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 775 (7th Cir. 2003), the plan administrator terminated benefits simply on the basis of a compulsory examination that concluded that Hackett was able to work contrary to numerous prior opinions. The examining doctor provided no explanation for his departure from the opinions of the previous doctors, and Xerox provided no explanation for believing this new opinion over the opinions of previous doctors. There was no weighing of the evidence for and against, and there were no articulated reasons given for Xerox's rejection of the evidence that Hackett was unable to work. The court ordered reinstatement of Hackett's benefits.

Here, as in *Hackett*, there was no weighing of medical evidence and the court should have ordered reinstatement of Petitioner's benefits. The lower courts' decisions directly conflict with *Hackett*.

B. *De novo* standard of review was required to be used by the district court

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 956, 103 L. Ed. 2d 80 (1989), this Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."

The circuit court agreed with the district court that the Plan gives the administrator discretionary authority where the Plan states that the administrator had the power "[t]o interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan." However, the Plan provides no discretionary authority to determine disability eligibility according to Capital One. Capital One admits that it did not have any discretion to determine the eligibility for disability benefits because the Plan gives no discretion in this area and requires disability benefits to be denied when a compulsory medical examination does not support disability. So, for $450.00, Capital One can deny benefits, regardless of the medical records and opinions of treating physicians, or the condition of the claimant. This is the real reason why Dr. Grana was not furnished with any medical records and why the treating

physicians were not interviewed by Capital One's agent, Aetna. There was no reason to do these things and expend the resources to investigate the medical condition and treatment plan when Capital One and Aetna have an easy out with an inadequate compulsory examination. This scheme violates the purpose, intent and spirit of ERISA.

In *Gilbertson v. Allied Signal, Inc.*, 328 F.3d 625, 631 (10th Cir. 2003), the court discussed *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and stated that "to be entitled to deferential review, not only must the administrator be given discretion by the plan, but the administrator's decision in a given case must be a valid exercise of that discretion." Although the circuit court found that the Plan provided that the plan administrator had discretion, Capital One conceded that the Plan did not provide any discretion with respect to denying a disability claim, because denial or termination was based solely on the opinion of the examining physician. The circuit court's decision directly conflicts with *Gilbertson*.

Black & Decker, *Hackett* and *Gilberston*, were all brought to the circuit court's attention by the Petitioner's notice of reliance on additional authority.

Capital One did not make any factual determination in terminating short-term benefits.

> Where an administrator has made no factual determination in denying plan benefits the district court should apply a *de novo* standard of review and arrive at its own factual findings in determining whether benefits were properly denied. However, the appropriate proceedings for

> such fact-finding is a bench trial and not the disposition of a summary judgment motion.

Casey v. Uddeholm Corporation, 32 F.3d 1094, 1099 (7th Cir. 1994). There is no factual determination by Capital One. Capital One just accepted the inadequate examining report and denied benefits on the basis that it was mandatory to do so.

In *Whatley v. CNA Insurance Companies*, 189 F.3d 1310, 1315 (11th Cir. 1999), the court reversed a summary judgment, holding that there were genuine issues of material fact precluding summary judgment as to whether the claimant was totally disabled where there were medical records indicating the existence of a serious medical condition, and an affidavit by a physician stating that the claimant may have been totally disabled. *See also Kirwan v. Marriott Corporation*, 10 F.3d 784 (11th Cir. 1994).

Here, the court had four treating physician's affidavits and medical records showing unequivocally that Margene Reid is totally disabled, which should have precluded summary judgment. Capital One conceded that the treating medical records and opinions meet the standard of disability in the Plan. For short-term benefits eligibility, the Plan merely requires that the claimant be unable to work due to sickness or injury. For long-term benefits, the Plan requires total disability and provides a definition.

Where someone other than the fiduciary makes the challenged benefit determination, a denial of plan benefits is reviewed under the *de novo* standard. *Sharkey v. Ultramar Energy Limited*, 70 F.3d 226, 229 (2d Cir. 1995). Here, the physician assigned to perform the compulsory medical

examination, Dr. Grana, made the decision to terminate benefits due to Capital One's position that the Plan provides no discretion, and Capital One must follow the findings of the examiner.

If an action is mandatory under the plan, the action taken must be reviewed *de novo*. *Baxter v. Lynn*, 886 F.2d 182, 188 (8th Cir. 1989). The denial of *de novo* review by the lower courts conflict with the Second and Eighth Circuits.

Under *de novo* review, the district court is not limited to the facts available to the administrator at the time of the determination. *Kirwan v. Marriott Corp.*, 10 F.3d 784, 789 (11th Cir. 1994). The district court is to review new evidence that was not part of the record before the plan administrator. *Moon v. American Home Assurance Co.*, 888 F.2d 86, 89 (11th Cir. 1989). The Third, Fourth, Seventh, Eighth and Ninth Circuits also permit the review of new evidence "to enable the full exercise of informed and independent judgment." *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 943 (9th Cir. 1995) (citations omitted). Thus, the lower courts should have considered the affidavits of the four treating physicians that found Margene Reid to be totally disabled, and also should have considered the deposition testimony of Dr. Grana which confirms that he was never provided all of the medical records, that the medical records would have been useful to him in his evaluation, and that he defers his opinion to the opinions of the treating specialists. With regard to his opinion, he did find Margene Reid to have a disability: tendinitis, temporomandibular joint disorder, and cervical disk disorder, which he opined should be resolved in six months. He did not know that Margene Reid was diagnosed with fibromyalgia. None of these conditions have resolved.

This Court's concern that employees and beneficiaries have at least as much protection under ERISA as the protection they had prior to the statute's enactment, warrants the exercise of discretion to admit evidence not before the plan administrator because of concerns about impartiality and ERISA's interest in providing protection for employees and their beneficiaries. *Quesinberry v. Life Insurance Company of North America*, 987 F.2d 1017, 1026 (4th Cir. 1993). If Margene Reid was making just an insurance claim, the insurer would have to weigh all of the medical evidence before determining coverage or benefits.

Capital One was required by the Plan's terms to talk to the treating and examining physicians to further explain their records and reports, and to assist on certification of eligibility. There was no discretion. Further, under a qualified ERISA plan, Capital One was required to investigate the claim and provide a "full and fair review." Capital One conceded that a full and fair review was never performed on the claim because the only evidence it considered was its examiner's report.

II. Certiorari Is Warranted Because The Decision Below Conflicts With, And Violates The Minimum Statutory Requirements Of ERISA

ERISA mandates a "full and fair review" of the evidence presented in a claim for benefits. A "full and fair review" requires evaluation of evidence presented by both sides. 29 U.S.C. § 1133(2) provides that "every employee benefit plan shall . . . afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." *Sweatman v. Commercial Union Insurance Co.*, 39 F.3d 594 (5th Cir. 1994); *Pilot Life*

Insurance Co. v. Dedeaux, 481 U.S. 41 (1987). Courts have explained that "full and fair review means 'knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy of the evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.'" *Sage v. Automation, Inc. Pension Plan & Trust*, 845 F.2d 885, 893-94 (10th Cir. 1988) (quoting *Grossmuller v. International Union Local 813*, 715 F.2d 853, 858 n.5 (3d Cir. 1983)).

29 C.F.R. § 2560.503-1 sets forth the minimum employee benefit claims procedures. 29 C.F.R. § 2560.503-1(h)(4) provides that

> The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

In order to provide a "full and fair review", 29 C.F.R. § 2560.503-1(h)(2)(ii) requires the plan to permit the "claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits." Paragraph (h)(2)(iv) requires that the review "takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination." Capital One concedes that this was not done because it only considered Dr. Grana's report.

Capital One initially gave notice of termination of benefits in its August 2, 1999 letter. Capital One stated that the report by Dr. Grana failed to confirm that Margene Reid was totally disabled as defined by the long-term disability definition. The letter also stated that "there was no clinical information to support continuing disability benefits" while confirming that Capital One had absolutely no medical records by treating physicians. Capital One agreed to consider all treating medical evidence if Reid would submit same, but Capital One did not. The letter failed to comply with the federal regulations which require the administrator to specifically explain to the claimant the standards necessary to perfect the claim. The letter failed to notify the claimant the need for additional information or material necessary to perfect the claim, describe the material and explain its relevance.

The regulations concerning the appeal of the denial of benefits permit the claimant to address the determinative issues and have a fair chance to present her case. 29 C.F.R. § 2560.503-1(f)(3) requires the administrator to notify the claimant the need for additional information or material necessary to perfect the claim, describe it, and explain its relevance. Paragraph (f)(3) requires the notice by the plan administrator to "specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, . . ." This enables the claimant "to appreciate the fatal inadequacy of his claim as it stands and to gain meaningful review by knowing with what to supplement the record." *Halpin v. W.W. Grainger, Incorporated*, 962 F.2d 685, 689 (7th Cir. 1992) (quoting *Wolf v. J.C. Penney Co.*, 710 F.2d 388, 392 (7th Cir. 1983). A blanket request for "additional medical information" does not satisfy the regulatory requirements. *Halpin*, at 691; *Wolf*, at 393.

Capital One's position that it must grant or deny disability benefits solely on the outcome of the compulsory medical examination to the exclusion of all medical evidence and information provided by the claimant and treating physicians violates these ERISA statutes and regulations, and is in direct contrast to this Court's decision in *Black & Decker Disability Plan v. Nord*, 537 U.S. 1098, 123 S. Ct. 1965, 154 L. Ed. 2d 766 (2003).

Under *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), federal courts are required to develop a "federal common law of rights and obligations under ERISA-regulated plans." *Id.* at 110 (quoting *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). The lower courts' decision ignores the obligations under ERISA and permits the Capital One Plan to exclude consideration of the treating physicians and make disability determinations solely on a compulsory examination.

The review procedure requires "the decision-maker to consider the evidence presented by both parties prior to reaching and rendering its decision." *Halpin*. at 689 (quoting *Brown v. Retirement Committee of Briggs & Stratton Retirement Plan*, 797 F.2d 521, 534 (7th Cir. 1986), *cert. denied*, 479 U.S. 1094 (1987). It is indisputable that the administrator cannot ignore the treating physicians and look only to the compulsory medical examination findings. The administrator is required to weigh the evidence for and against disability, and "within reasonable limits, the reasons for rejecting evidence must be articulated if there is to be meaningful appellate review." *Halpin*, at 695 (quoting *Young v. Secretary of Health & Human Services*, 957 F.2d 386, 393 (7th Cir. 1992).

ERISA and its accompanying regulations were intended to help claimants process their claims efficiently and fairly; they were not intended to be used by employers and administrators as a smoke screen to shield themselves from legitimate claims. *Halpin*, at 696.

Capital One's determination of denial of benefits solely on the basis of Dr. Grana's limited examination is repugnant to the requirements of ERISA. A "full and fair review" requires all medical evidence to be considered and evaluated. Margene Reid was never afforded a "full and fair review" and thus was denied her statutorily mandated, and judicially determined, rights.

It is well-settled that "where the plan administrator has failed to comply with ERISA's procedural guidelines . . . the proper course of action for the court is remand to the plan administrator for a 'full and fair review.'" *Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F.2d 154, 159 (4th Cir. 1993); see also *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1006 n.4 (4th Cir. 1985). Numerous other jurisdictions have likewise adopted this sound legal principle, namely that the remedy for a procedural error committed during the administrative process—such as the plan's failure to provide adequate notice of a claim denial—is a remand to the plan administrator for a redetermination of the claim. *See, e.g., Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 776 (7th Cir. 2003) ("[i]n a case where the plan administrator did not afford adequate procedures in its initial denial of benefits, the appropriate remedy respecting the status quo and correcting for the defective procedures is to provide the claimant with the procedures that she sought in the first place"); *Syed v. Hercules, Inc.*, 214 F.3d 155, 162 (3d Cir. 2000) (recognizing that "[w]here a termination letter does

not comply with the statutory and regulatory requirements . . . the remedy . . . is to remand to the plan administrator so the claimant gets the benefit of a full and fair review").

III. Certiorari Is Warranted Because The Decision Utilized The Wrong Standard Of Review

Under an abuse of discretion standard of review, in the absence of bad faith or conflict of interest, a court may overturn the administrator's decision only if it is without reason, unsupported by substantial evidence, or erroneous as a matter of law. *Donaho v. FMC Corporation*, 74 F.3d 894, 900 (8th Cir. 1995). In evaluating whether an administrator's disability determination is reasonable, courts are to look to whether the decision is supported by substantial evidence. Substantial evidence is a quantified reformation of reasonableness. The unreasonableness of an administrator's decision can be determined by both the quantity and quality of the evidence supporting it. *Id.* Where the evidence indicating disability was overwhelming, a denial of benefits is unreasonable. *Id.* at 901.

All three of *Donaho*'s factors are present. Here, there is overwhelming evidence showing that Margene Reid is unable to work due to her injuries as required by the short-term income protection provision of the Plan. In fact the overwhelming evidence is that Margene Reid is totally disabled as required by the long-term provisions of the Plan. The quality and quantity of this evidence favors approving benefits. Capital One's reliance on the limited examination by Dr. Grana was unreasonable, especially since Dr. Grana was not furnished with the treating physician's records. Further, the failure to consider the evidence presented by Margene Reid renders Capital One's decision erroneous as a matter of law.

To determine whether an administrator's decision is arbitrary and capricious, the reviewing court must determine whether the decision is supported by substantial evidence. Substantial evidence is that relevant evidence which a reasonable mind might accept as adequate to support a conclusion. *Dobrowolsky v. Califano*, 606 F.2d 403, 406 (3d Cir. 1979). It is not sufficient that the decision was based only on *some* evidence. *Brown v. Retirement Committee of Briggs & Stratton Retirement Plan*, 797 F.2d 521 526-27 (7th Cir. 1986), *cert. denied*, 479 U.S. 1094 (1987). A decision to terminate benefits is arbitrary and capricious where the administrator did not have a current medical assessment of the claimant's condition by a physician familiar with the claimant's current symptoms and some assessment of the claimant's pain. *Riley v. UNUM Insurance Company of America*, 1998 WL 839881*5 (D. Kan. 1998).

Here, Margene Reid provided Capital One with her medical records to review and evaluate, but Capital One chose to ignore them. Capital One did not contact any of the doctors, including its own examining doctor, Dr. Grana, to determine Margene Reid's pain and current medical assessment. Thus, Capital One's denial of benefits was arbitrary and capricious.

Capital One is self-funded for short-term benefits and is fully insured for long-term benefits with Aetna. An employee cannot receive long-term benefits without exhausting short-term benefits. The first day following six months of short-term disability is when an employee is eligible for long-term disability benefits.

Because Capital One pays out to beneficiaries from its own assets for short-term disability benefits, a conflict of

interest exists between its fiduciary role and its profit making role. Capital One contended that its conflict of interest is minimal because Capital One only had to pay out of its pocket one more month of short-term benefits. However, Capital One ordered the compulsory examination and denied the short-term benefits knowing that doing so would prevent any exposure on their part. Capital One's committee vote was just in collaboration with Aetna and a way to keep insurance premiums maintained. This conflict of interest requires no deference to be given to Capital One's denial of benefits.

Where there is a conflict of interest, a less deferential level of review is appropriate. This conflict must be weighed as a factor in determining whether Capital One abused its discretion under the plan. *Firestone*, 489 U.S. at 115, 109 S. Ct. 948. Since *Firestone*, "all of the circuit courts agree that a conflict of interest triggers a less deferential standard of review." *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996); *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, 1474 (9th Cir. 1993) ("Because [of a conflict of interest], we therefore impose a more stringent version of the abuse of discretion standard. . . .").

A plan administrator abuses its discretion if it (1) renders decisions without explanation; (2) construes provisions of the plan in a way that conflicts with the plain language of the plan; or (3) relies on clearly erroneous findings of fact in making benefit determinations. *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469, 1472-73 (9th Cir. 1993). Here, Capital One ignored all of the treating physicians opinions, did not follow the Plan requirements of directly contacting the treating physicians, did not obtain treating physicians' records for review by the examining physician, did not obtain

an examining physician specializing in the areas of the treating physicians. Capital One abused any discretion it may have had.

An ERISA plan administrator abuses its discretion if it construes provisions of the plan in a way that conflicts with the plain meaning of the plan. *Saffle v. Sierra Pacific Power Company Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 458 (9th Cir. 1996).

"The more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." *Elliott v. Sara Lee Corporation*, 190 F.3d 601, 605 (4th Cir. 1999), (citing *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d 228, 233 (4th Cir. 1997)).

In *Gunderson v. W. R. Grace & Co. Long Term Disability Income Plan*, 874 F.2d 496, 499 (8th Cir. 1988), the court stated that before terminating benefits, the administrator should have obtained a vocational expert's opinion to determine if Gunderson was capable of performing any occupation. The court held that without this information, the court could not say there was substantial evidence to support the administrator's decision.

Dr. Grana recommended to Capital One that Margene Reid should undergo a functional capacity evaluation, which he is not qualified to perform. Capital One ignored his recommendation and did not authorized the evaluation. This is further evidence of Capital One's arbitrary and capricious nature of its handling of this claim.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED AND FILED JUNE 17, 2003

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 02-13913

D. C. Docket No. 01-00129-CV-T-27

MARGENE REID,

Plaintiff-Appellant,

versus

CAPITAL ONE FINANCIAL CORPORATION,
a foreign corporation,

Defendant-Appellee.

Appeal from the United States District Court
for the Middle District of Florida

(June 17, 2003)

Before BARKETT and MARCUS, Circuit Judges, and MILLS*, District Judge.

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* Honorable Richard Mills, United States District Judge for the Central District of Illinois, sitting by designation.

Appendix A

PER CURIAM:

Appellant Margene Reid appeals from the district court's order granting summary judgment in favor of Appellee Capital One Financial Corporation ("Capital One") on her claims brought pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001- 1461 ("ERISA"). Reid argues that the district court erred by applying a heightened arbitrary and capricious standard of review to her plan administrator's decision to deny her disability benefits and by determining that the administrator had acted in accordance with the terms of the plan in any event.

We review a district court's grant of summary judgment *de novo*. *See Madray v. Publix Supermarkets, Inc.*, 208 F.3d 1290, 1296 (11th Cir. 2000). In doing so, "we must view all the evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party." *Stewart v. Happy Herman's Cheshire Bridge, Inc.*, 117 F.3d 1278, 1285 (11th Cir. 1997).

Upon thorough review of the record as well as careful consideration of the parties' briefs and oral arguments, we find no reversible error. The district court correctly ruled that an arbitrary and capricious standard of review is appropriate where, as here, the plan explicitly grants the administrator discretion to determine eligibility for benefits and to construe the terms of the plan. *See Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989). The district court was also correct to apply the "heightened" arbitrary and capricious standard, because Capital One both administers the plan and pays benefits. *See HCA Health Servs.*

of Ga. Inc., v. Employer's Health Ins. Co., 240 F.3d 982, 1001 (11th Cir. 2001). Lastly, we agree with the district court that the administrator correctly denied Reid disability benefits under the terms of the plan, because the plan explicitly requires an independent medical examination to confirm the claimant's disability and an independent medical examination did not confirm Reid's.

Simply put, we affirm based on the well-reasoned and comprehensive opinion of the district court.

AFFIRMED.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION DATED JUNE 13, 2002 AND FILED JUNE 17, 2002

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No. 8:01-CV-129-T-27TGW

MARGENE REID,

Plaintiff(s),

vs.

CAPITAL ONE FINANCIAL CORPORATION, a foreign corporation, and AETNA US HEALTHCARE, a foreign corporation,

Defendant(s).

ORDER

THIS CAUSE came on to be considered on Defendant Capital One's Motion for Summary Judgment (Dkt. 17), Plaintiff's Amended Response to Defendant's Motion for Summary Judgment (Dkt. 31) and Plaintiff's Motion for Summary Judgment (Dkt. 40). The Court having reviewed said pleadings, the record and applicable case authority, having heard oral argument on April 23, 2002 and being otherwise fully advised in the premises, concludes that

Appendix B

Defendant Capital One's Motion for Summary Judgment should be granted, there being no disputed issues of material fact. Likewise, Plaintiff's Motion for Summary Judgment should be denied.

I. Factual Background

Capital One Financial Corporation ("Capital One") provided its employees with an integrated short-term and long-term disability benefits program ("the Plan"). The short-term and long-term disability benefits program is administered in part and insured in part by Aetna Life Insurance Co. ("Aetna")[1]. Short-term disability benefits are "self insured" by Capital One while long-term disability benefits are insured by Aetna. (*See generally* Mikasa Dep., at 12-14, 16, 44; Mikasa Aff., Ex. 4).

The Plan provides that Capital One has the authority to make and enforce plan rules, establish claims procedures, interpret the Plan and decide claims for benefits. (Mikasa Aff., Ex. 1, s. 7.1, s. 2.1 and s. 2.15). Capital One has delegated some of this authority to Aetna. Eligibility for short-term benefits is determined in the first instance by Aetna, subject to a one time appeal to Aetna, followed by an appeal to Capital One. (Mikasa Dep. at 17-19, 44). Eligibility for long-term benefits is determined by Aetna, subject to a single appeal to Aetna without further appeal to Capital One.

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1. The parties disagree on whether Aetna US Healthcare or Aetna Life Insurance Company is the Plan Administrator for long-term disability benefits.

(*Id.* at 54). Accordingly, Capital One is self funded for short-term benefits and has provided long-term disability benefits under the Plan by purchasing coverage from Aetna.

The Plan provides that short-term disability benefits last 26 weeks and thereafter, long-term disability benefits apply. (Plaintiff's Ex. 1 at CO0677, CO0681, 809-810, 813). An employee cannot receive long-term benefits without exhausting short-term benefits. An employee becomes eligible for long-term disability benefits on the first day following six months of short-term disability benefits. (Mikasa Dep. at 16, 54).

The standard for "disability" under the Plan during the first 24 months of a disability is generally whether the participant is "not able, solely because of disease or injury, to perform the material duties of your own occupation." (Mikasa Aff., Capital One's Ex. 4 at CO0837). The Plan provides that benefits will not be approved if a "requested Independent medical examination . . . fails to confirm your disability." *Id.* at CO0838. (*See also* Mikasa Dep. at 46).

The Plan also provides that Aetna is required to call the employee's doctors to verify the employee's diagnosis and treatment plan. (Plaintiff s Ex. 1 at CO0678). The employee's treating physician is to certify the employee's disability by working with Aetna's medical representatives and Capital One's Managed Income Protection coordinator. (Plaintiff's Ex. 1 at CO0681).

Margene Reid ("Plaintiff") was a full time employee of Capital One. Shortly after beginning employment with

Capital One, she was injured in two automobile accidents which occurred in January and February 1999. (Capital One's Ex. 9 at CO0229). Plaintiff became disabled and did not work from February 21, 1999 through May 10, 1999 (Reid Dep. at 44). Thereafter, Plaintiff returned to work as a part-time employee and received short-term disability benefits under the Plan for approximately five months. In July 1999, Aetna referred Plaintiff for an Independent Medical Examination ("IME") to Dr. Erick A. Grana. (Mikasa Aff., Defendant's Ex. 9 at CO0286-289). Dr. Grana examined Plaintiff and reported that

> At this stage, over five months following the second motor vehicle accident, I do not think the patient needs any further conservative treatment for these soft tissue injuries. The patient should also be able to return to work, full duty. She has been working five days a week and up to five hours per day. She should be able to increase that to eight hours per day or working full-time, full duty.

Id. at CO0289. Based on this opinion, Aetna determined and informed Plaintiff that her short-term disability benefits would be discontinued effective July 28, 1999, subject to an appeal "in writing to this office." *Id.* at CO0236-237. This letter explained the reasons for the denial pursuant to the terms of the Plan and informed Plaintiff of her right to appellate review. *Id.*

Plaintiff appealed by letter dated September 23, 1999. *Id.* at CO0279. Following her submission of additional

medical evidence, Plaintiff's appeal was denied on March 2, 2000. CO0229-230. Aetna's denial letter noted the terms of the Plan deferring to the opinion of the IME, noting Dr. Grana's opinion and advising that the medical evidence submitted by Plaintiff had been reviewed by an Aetna medical director. *Id.*

After Aetna denied Plaintiff's short-term disability claim, Aetna referred Plaintiff to Capital One for a final appeal pursuant to the Plan, which Plaintiff initiated by letter dated March 21, 2000. *Id.* at CO0228. In response, Capital One's Benefits Manager, Mikasa, wrote Plaintiff that she had the right to submit additional evidence for a period of thirty days after filing her appeal and that her claim would then be decided. *Id.* at CO0277. Plaintiff's counsel provided one additional doctor's note by letter dated April 28, 2000. *Id.* at CO0345.

Following the preparation of a memorandum summarizing the information provided to Capital One, a committee reviewed Plaintiff's file. (Mikasa Dep. at 46-7). The committee noted that Plaintiff had terminated her relationship with one of her doctors, Dr. Tedder, immediately after he had recommended that she return to work. (Mikasa Dep. at 46-47; Reid Dep. at 19-20; and Mikasa Aff. Exhibit 9 at CO0372). By letter dated May 30, 2000, Plaintiff's claim was denied "as there was no medical information provided to contradict the findings of the independent medical examination." (Capital One's Ex. 9 at CO0174).

After February 2, 2000, Plaintiff stopped working due to the injuries she sustained in these accidents. (Capital One's

Ex. 9, Randolph's Memo). As of February 3, 2000, Aetna considered this a separate period of disability for Plaintiff as though she had recovered and returned to work fulltime for some period prior to February 3, 2000. (Reid Dep. at 44).

On April 17, 2000, Aetna issued a denial letter, which by its terms applied only to the period after February 3, 2000. *Id.* The denial letter refers to a second IME conducted by Dr. Grana on March 31, 2000, in which he opined,

> [I]t is my professional opinion that the patient is not completely and permanently disabled as a result of the two motor vehicle accidents suffered in 1999. The patient shall be able to perform job du ies at a minimum at the light/medium work capacity.

(Capital One's Ex. D at last page). The record does not reflect that Plaintiff filed an appeal. Rather, on January 18, 2001, Plaintiff filed her action in this Court.

II. Standard Applicable to Summary Judgment

Summary judgment is proper if following discovery, the pleadings, depositions, answers to interrogatories, affidavits and admissions on file show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986); FED. R. CIV. P. 56. The Court must view all evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970); *Stewart v. Happy Herman's Cheshire Bridge, Inc.*, 117 F.3d

1278, 1285 (11th Cir. 1997). Judgment in favor of a party is proper where there is no legally sufficient evidentiary basis for a reasonable jury to find for the nonmoving party on the issue before the Court. FED. R. CIV. P. 56.

Once a party properly makes a summary judgment motion by demonstrating the absence of a genuine issue of material fact, whether or not accompanied by affidavits, the nonmoving party must go beyond the pleadings through the use of affidavits, depositions, answers to interrogatories and admissions on file, and designate specific facts showing that there is a genuine issue for trial. *Celotex*, 477 U.S. at 324. The evidence must be significantly probative to support the claims. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986).

III. Discussion

1. Defendant's Claim Decision for the First Period of Disability (Period after February 21, 1999)

a. Plan Affords Administrator Discretion in Determining Eligibility Benefits

Where an ERISA plan grants discretionary authority to determine eligibility for benefits or to construe its terms, the administrator's decision denying benefits may be reversed only when the administrator's decision was arbitrary and capricious or an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). Under the arbitrary and capricious standard, the function of a reviewing court is to determine whether there was a reasonable basis for the

decision based on the facts known to the administrator at the time the decision was made. *See Buckley v. Metropolitan Life*, 115 F.3d 936 (11th Cir. 1997) (*citing Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989)). An administrator's decision will not be disturbed if reasonable. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989); *see also Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 38-39 (11th Cir. 1989). In applying the arbitrary and capricious standard, the Court's role is "'limited to determining whether [Defendant's] interpretation was made rationally and in good faith — not whether it was right.'" *Guy*, 877 F.2d at 39 (*quoting Anderson v. Ciba-Geigy Corp.*, 759 F.2d 1518, 1522 (11th Cir. 1985)). The Court may look only to the facts known to the administrator at the time of the decision denying coverage. *Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989). Provided there is some reasonable basis for Defendant's decision, it must be upheld as not being arbitrary and capricious, even if there is evidence to support a contrary decision. *See Jett*, 890 F.2d at 1139; *see also Blank v. Bethlehem Steel Corp.*, 926 F.2d 1090, 1093 (11th Cir. 1991).

Here, the Plan expressly provides that Capital One has discretionary authority to interpret and apply the Plan. (CO0624). Specifically, the Plan provides that the Plan Administrator has the power "[t]o interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan." *Id.* Accordingly, the Plan, in unambiguous terms, grants Defendant discretionary authority to interpret whether Plaintiff was entitled to "short-term disability benefits."

Appendix B

Payne v. Ryder System, Inc. Long Term Disability Plan, 173 F.R.D. 537, 542-43 (M.D. Fla. 1997). Accordingly, the denial of Plaintiff's short-term disability benefits is reviewed under the arbitrary and capricious standard with deference to its factual determinations absent a conflict of interest. *Levinson v. Reliance Standard Life Insurance Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001).

Heightened Arbitrary and Capricious Standard

In certain cases, a heightened standard of review is appropriate when an insurer is also the claims fiduciary under an ERISA plan and a conflict of interest exists. *Levinson*, supra; *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991). When a conflict of interest exists, the claims administrator's interpretation of the plan is not entitled to deference. *HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 994 (11th Cir. 2000). For example, an administrator acts under a conflict of interest if it pays claims out of its own assets. *Id.* at 1001. Here, Defendant admits that it acts as the Administrator of its own policy and pays claimants out of its own assets. (Admission in Open Court, 4/23/02). Accordingly, its claims decision is subject to the heightened arbitrary and capricious standard. *Levinson*, supra.

Notwithstanding the applicability of the heightened arbitrary and capricious standard of review, it is "fundamental that the fiduciary's interpretation first must be 'wrong' from the perspective of *de novo* review before a reviewing court is concerned with the self-interest of the fiduciary." *Id.*

(*quoting Brown*, 898 F.2d at 1566 n.12). A decision is "wrong" if, after reviewing the plan documents and disputed terms *de novo*, the court disagrees with the administrator's plan interpretation. *HCA Health Services*, 240 F.3d at 993 n.23.

Capital One's decision to terminate Plaintiff's short-term disability benefits was pursuant to a provision of the Plan which required that benefits be terminated if an independent medical examination fails to confirm a participant's disability. The Plan provided that benefits would not be approved if a

> Requested independent medical examination . . . fails to confirm your disability. (Mikasa Aff., Ex. 4 at CO0838)

Capital One's decision to terminate Plaintiff's short-term disability benefits was consistent with this provision.

Pursuant to Dr. Grana's July 1999 IME report, information provided by Plaintiff, her physician, AETNA and the plan documents, the Capital One's Benefits Committee reasonably determined that Plaintiff could perform the sedentary duties of her customer relations associate position without any additional time off. (CO0174). Although Plaintiff's physicians' opinions differed from the IME report, Capital One was authorized to resolve any conflicting opinions among the medical professionals when the "decision came down to a permissible choice between the position of [the insurance company's] independent medical consultant and the position of [the claimant's physicians]". *See Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994).

Appendix B

Although Plaintiff maintains that Defendant failed to comply with the provision in the Plan which required Aetna to call her physicians to verify her diagnosis and treatment plan, (*see* Plaintiff's Ex. 1 at CO0678), that omission does not establish that Defendant's decision was arbitrary, capricious or unreasonable.[2] The Plan unambiguously states that if the requested IME fails to confirm Plaintiff's disability, benefits would not be approved. (*See* Mikasa Aff., Ex. 4 at CO0838). Plaintiff's IME did not confirm any disability. Rather, an independent physician concluded after examining Plaintiff that she should be able to return to work, full duty and that no further conservative treatment was needed for Plaintiff's soft tissue injuries. (Mikasa Aff., Defendant's Ex. 9 at CO0286-289). Given the conclusions of the IME physician, Defendant acted reasonably and in accordance with the terms of the Plan in denying Plaintiff's request for benefits.

Here, Capital One's Administrator had a reasonable basis for the decision, based upon the facts known to her at the time the decision was made, to wit, Dr. Grana's IME report. *See Levinson*, 245 F.3d at 1326; *HCA Health Services*, 240 F.3d at 994; *Jett*, 890 F.2d at 1139; *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1451 (11th Cir. 1997). After a *de novo* review of the record, the Court finds Defendant's decision to deny the benefits was not "wrong", and accordingly it is unnecessary to address whether Defendant was acting with the self-interest of a fiduciary. *Payne*, 173 F.R.D. at 542-43.

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2. Plaintiff's treating physician, Dr. McGinn, had relocated at the time of Defendant's decision and was unavailable. Plaintiff's treatment with Dr. Bolin for her TMJ injury began after Defendant made its decision and therefore Dr. Bolin was not available.

Appendix B

To the extent that Plaintiff now relies on evidence or theories that were not presented to Capital One during the administrative decision making process, Plaintiff is barred from raising those new theories, argument or evidence. An administrator must make a decision "based upon the facts known to the administrator at the time the decision was made". *Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1139 (11th Cir. 1987) (under arbitrary and capricious standard); *accord Ravenscraft v. Hy-Vee Employee Benefit Plan and Trust*, 85 F.3d 398, 401-02 (8th Cir. 1996) (refusing to consider new theory even under non-discretionary, *de novo* review).

3. Exhaustion of Administrative Remedies for the Second Period of Disability (Period after February 3, 2000)

Capital One argues that Plaintiff has not exhausted her administrative remedies for her claim to benefits for the period after February 3, 2000. In *Mason v. Continental Group, Inc.*, 763 F.2d 1219 (11th Cir. 1995), *cert denied*, 474 U.S. 1087 (1986), the Eleventh Circuit explained the need for exhaustion in ERISA cases:

> Compelling considerations exist for plaintiffs to exhaust administrative remedies prior to instituting a lawsuit. Administrative claim-resolution procedures reduce the number of frivolous lawsuits under ERISA, minimize the cost of dispute resolution, enhance the plan's trustees' ability to carry out their fiduciary duties expertly and efficiently by preventing premature judicial intervention in the decisionmaking

> process, and allow prior fully considered actions by . . . trustees to assist courts if the dispute is eventually litigated.

763 F.2d at 1227. *See also Springer v. Wal-Mart Associates' Group Health Plan*, 908 F.2d 897, 900 (11th Cir. 1990) ("no longer open to serious dispute that plaintiffs in ordinary breach-of-contract ERISA actions must normally exhaust available administrative remedies.").

Defendant's argument in this regard has merit. Plaintiff stopped working entirely in early February 2000. As Capital One acknowledges, for reasons which are not entirely clear, Aetna considered the time after February 3, 2000, as a separate period of disability for Plaintiff, consistent with treating Plaintiff as though she had recovered and returned to work full time for some period prior to February 3, 2000 (which she had not done, Reid Dep. at p. 44).

Plaintiff's counsel was on notice that Aetna considered the period after February 3, 2000 as a new and separate claim, as evidenced by his correspondence dated April 5, 2000. (Mikasa Dep., Ex. 1, #270). Thereafter, Aetna issued a denial letter on April 17, 2000, which by its terms applied only to the period after February 3, 2000. Despite having received this denial letter for the period after February 3, 2000, Plaintiff did not pursue her appeal as provided in the Plan. Under the Plan, eligibility for short-term benefits is determined in the first instance by Aetna, and then reviewed by a first appeal to Aetna, followed by a second appeal to Capital One. (Mikasa Dep. at 17-19, 44). Accordingly, Plaintiff has not exhausted her available administrative remedies for her claim for benefits after February 3, 2000.

For the foregoing reasons, the Court finds that there are no material issues of disputed fact and Capital One's Motion for Summary Judgment (Dkt. 17) should be and is hereby GRANTED. Plaintiff's Motion for Summary Judgment (Dkt. 40) should be and is hereby DENIED.[3] The Clerk is direct to close this file and terminate any pending motions.

DONE AND ORDERED in chambers this 13th day of June, 2002.

s/ James D. Whittemore
JAMES D. WHITTEMORE
United States District Judge

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3. To the extent that Plaintiff arguably sought long-term disability benefits from Capital One, that claim is properly brought against the appropriate Aetna entity, rather than Capital One.

APPENDIX C — STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1001. Congressional findings and declaration of policy

* * *

(b) It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

* * *

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Appendix C

29 C.F.R. § 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. § 1133, § 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). ***

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

* * *

Appendix C

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. ***

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. ***

(iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

* * *

Appendix C

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

* * *

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

* * *

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim,

without regard to whether such information was submitted or considered in the initial benefit determination.

* * *

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

* * * *